Agenda Item 3
12/20/06 Meeting

Managed Risk Medical Insurance Board
November 15, 2006

Board Members Present:	Cliff Allenby, Areta Crowell, Ph.D., Virginia Gotlieb, M.P.H., Sophia Chang, M.D., M.P.H., Richard Figueroa, M.B.A
Ex Officio Members Present:	Warren Barnes (for Ed Heidig), Bob Sands (for Joe Munso), Jack Campana
Staff Present:	Lesley Cummings, Laura Rosenthal, Janette Lopez, Glenn Hair, Ruth Jacobs, Dennis Gilliam, Mary Anne Terranova, Ernesto Sanchez, Larry Lucero, Kathy Dobrinen, Carolyn Tagupa, Ruben Mejia, Rose Lamb, Sarah Swaney, Thien Lam, Adrienne Thacker, Melissa Ng

Chairman Allenby called the meeting to order and recessed it for executive session. At the conclusion of executive session, the meeting was reconvened.

REVIEW AND APPROVAL OF MINUTES OF October 25, 2006 MEETING

A motion was made and unanimously passed to approve the minutes of the October 25, 2006, meeting.

HEALTHY FAMILIES PROGRAM (HFP) UPDATE

Enrollment and Single Point of Entry Reports

Ernesto Sanchez reviewed the monthly enrollment reports. As of October 31, 2006, 777,031 children were enrolled. Chairman Allenby asked if there were any questions or comments. There were no questions or comments from the Board or the public.

Administrative Vendor Performance Report

Mr. Sanchez reviewed the monthly report performance report. The vendor met all the contractual requirements for processing applications at single point of entry and the telephone line requirements. Mr. Sanchez also reviewed the vendor's

performance in meeting accuracy standards. These standards will become contractually required for November performance but Maximus is voluntarily reporting them now. These accuracy standards are the highest in the country (98%). The vendor met all of the standards. Chairman Allenby asked if there were any questions or comments. There were no questions or comments from the Board or the public.

Enrollment Entities/Certified Application Assistants Reimbursement Report (EE/CAA)

Larry Lucero provided the Board with an update on the foregoing report. To date 4.5 million has been paid out to enrollment entities for application assistance since February 2005. Approximately $ 1.2 million has been paid for this fiscal year 2006/07. Chairman Allenby asked if there were any questions or comments. There were no questions or comments from the Board or the public.

Department of Health Services Report on County Outreach Grants

Kennalee Gable from the Department of Health Services updated the Board on the Medi-Cal/HFP outreach grants

There are two levels of county allocations. Level 1 consists of the 20 larger counties that have 93 percent all eligible, but not enrolled, children. $16.68 million will be allocated to these counties based on their number of unenrolled, but eligible, children and current HFP and Medi-Cal case-wide. Level 2 consists of all the other counties and a total of $3 million has been set aside for them. Level 2 counties may apply for funding if they demonstrate that they have an established coalition for children's outreach and enrollment that had been in place for at least 12 months. The prospective Level 2 counties were directed to submit a plan and budget that did not exceed $288,000 in each fiscal year. DHS received 14 Level 2 county plans and budgets. DHS is currently reviewing the Level 1 county plans and budgets to insure the county adequately responded to all of the submission criteria.

DHS expects to approve plans beginning later this month and then will focus on Level 2 counties. The evaluation process will begin this week. Ms. Gable asked if there were questions.

Dr. Crowell stated the Board has great concern that the funding get out to the counties. The Board wants to see the outreach happening and the kids getting enrolled. Dr. Crowell asked why it was taking so long to get the funds out to counties that already had programs in place. Dr. Crowell indicated that she would like DHS to give periodic updates to the Board. Ms. Gable stated that the outreach program is new and DHS had to

develop a process for disbursing the funds. DHS got the solicitation out during late August and September 2006. The plans were due on October 10th. DHS needed to go back to the counties to get some clarifying information. DHS will be happy to provide the Board with regular updates. Chairman Allenby and Dr. Crowell were pleased to hear this. Chairman Allenby asked if there were any questions or comments. There were none.

Research Study on SCHIP Funding Reauthorization

Ms. Cummings reminded the Board that Congress will be addressing the requirements for SCHIP funding beyond FFY 07 in the next Congressional session. It will be critical for California, which has the largest SCHIP program in the country, to have a way to articulate its funding needs and analyze the proposals Congress considers. The California Health Care Foundation has graciously agreed to finance a project along these ends, and has hired Harbage Consulting for the project. Ms. Cummings acknowledged Peter Harbage, and asked him to describe the project to the Board.

Mr. Harbage stated the California Health Care Foundation has agreed to take a hard analytical review of SCHIP funding developments in the upcoming year. Harbage Consulting will produce three different papers on the topic between now and April 15, 2007. The first will be a projection of California's SCHIP funding requirements over the next five years. Last time, Congress provided funding for a ten-year timeframe. The second paper will look at potential statutory changes that would improve the program. Examples may include covering legal immigrants or changes in caps on administrative spending that could benefit states for more efficient operations. The third paper will review and assess the funding variables that could go into a formula for allocating funds to the states. The original SCHIP formula used factors appropriate for a new program. It was based on the number of uninsured children and the number of low-income children. With reauthorization – ten years later -- there will be a new formula, and much more discussion about how to allocate the dollars among the states. Additionally, the third paper will include a model that MRMIB can use to evaluate various options the Congress is considering. After these papers are done, Harbage Consulting will present the papers to California stakeholders and also conduct a series of briefings for congressional staff. Chairman Allenby asked if there were any questions or comments.

Mr. Figueroa asked when the reports would be complete. Mr. Harbage stated the deliverables will be completed between now and April 2007. The first paper will be completed by January, the second (on

programmatic changes) in late February or early March, and April 2007 for the analysis of formula issues and the development of the model.

Chairman Allenby asked if there were any further questions or comments. Ms. Cummings thanked the California Healthcare Foundation. She also noted that Mr. Harbage was working for the CMS Secretary when the first SCHIP formula was developed. Chairman Allenby stated this project is greatly needed. He then called for public comment.

Deena Lahn from the Children's Defense Fund (CDF) and the 100% Campaign stated her organization very much supports the project. CDF hopes that the Governor and other supporters of children's health coverage will take a very aggressive stand on the SCHIP issue nationally. Ms. Lahn acknowledged that California has the most to lose or the most to gain. Ms. Lahn addressed that many organizations have seen the need to ramp up what needs to occur with SCHIP. CDF hopes that the Governor and all other supporters of Children's Health in California will take a very aggressive stance. There have been factors that really impact California, such as federal funding for legal immigrants that could really be helpful for California, even though California is already doing the right thing by covering these children at full state cost.

Mr. Figueroa noted CDF's critical role in enactment of SCHIP and asked if CDF has a list of items or changes that CDF wants to see implemented? Ms. Lahn stated CDF national is proposing a major new initiative to cover all children whose incomes are 300% of FPL or below. CDF sent out a letter to governors and congress people this week announcing this initiative. California's not the only state that has run out of money but California is in a unique position to influence the national legislation.

Ms. Lahn noted that in some respects what CDF is promoting nationally are things that have already been implemented in California. These include continuous eligibility for one year. Their goal is to bring other states up to California's level. Mr. Figueroa thanked Ms. Lahn for her presentation.

Chairman Allenby also thanked Ms. Lahn and asked if there were any more questions or comments. Ms. Cummings stated staff anticipates having filled our Legislative Deputy position by the next board meeting, and that working on the issue of SCHIP funding will be the highest priority for that position. Chairman Allenby asked if there were any further questions or comments. There were no further questions or comments from the Board or the public.

Staff Analysis of UCSF's Recommendations for Improving Services for HFP Children with Serious Emotional Disturbances

At a previous meeting, the Board had reviewed a report prepared by the University of California at San Francisco and funded by The California Endowment that made a number of recommendations for improving the delivery of services to children with Serious Emotional Disturbances (SED). Rosie Lamb, Benefits and Quality Monitoring staff member presented a paper to the Board that summarized these recommendations and described how staff would implement them. Several recommendations center on the reinstatement of the work group with Healthy Families Program plans and the counties. Staff will also address the referral process, the parent education and the resolution process where there are disputes between the plans and the counties.

In addition, staff will attend OAC meetings and will be issuing a policy statement in January 2007 that outlines plan responsibilities when counties do not have sufficient resources to treat SED youth. Staff will have a meeting on Monday with a member of the American Academy of Pediatrics Mental Health Task Force to review their work on the screening tools, also addressed in the UCSF report.

Chairman Allenby asked if there were any questions or comments.

Dr. Crowell stated she was delighted to see staff moving assertively, following up on the study and the recommendations. She indicated that she also wanted to be sure that the workplan included periodic meetings with Steve Mayberg, Director of the Department of Mental Health. She indicated that it was important to keep Dr. Mayberg closely involved in what staff at MRMIB finds and make sure the implementation goes forward.

Mr. Campana stated in the past there has been friction with mental health departments and schools on who should be doing what in reference to AB 3632. He asked what the role of schools was in the delivery of SED services to HFP children. He is concerned about issues like whether a child expelled due a school's zero tolerance rule should have a mental health assessment as part of an expulsion process? Where does the dialoguing start with education on many of the issues of children with SED? Ms. Cummings stated she does not have a good answer to these questions. But she does not think this is an HFP-specific issue. It is an overall SED system issue. The issue is with the Department of Mental Health, the county mental health departments, and education. Ms. Cummings also stated the effort needs to be there to get the conversation going. Mr. Campana agreed with Mr. Allenby and Ms. Cummings but felt that if education isn't included in the dialogue somewhere, a major

opportunity is missed. Ms. Cummings stated that Mr. Campana should attend a meeting with her and Dr. Mayberg where Mr. Campana can raise those issues. Mr. Campana thought this was a productive idea.

Chairman Allenby asked if there were any further questions or comments. There were no further questions or comments from the Board or the public.

Phases II and III Solicitation for an Evaluation of HFP Mental Health and Substance Abuse Services – (first draft)

Ruben Mejia presented the first draft of the solicitation for evaluation of plan-provided mental health and substance abuse services. The final solicitation document will be presented at the Board meeting in December.

This evaluation follows the evaluation of SED services conducted by UCSF. One vendor will be selected to complete both of these evaluations (Phases II and Phase III).

Mr. Mejia reviewed the key issues to be addressed in the two evaluations. The funding for the evaluation is $266,000 over two years. On January 18, 2007 MRMIB will hold a bidder's conference. Proposals are due February 21, 2007. Staff will recommend a contractor at the Board meeting on March 28, 2007. Chairman Allenby asked if there were any questions or comments. Dr. Crowell and Chairman Allenby both said the staff did a good job and thanked the staff.

Dr. Chang recommended that staff should take the opportunity to review the draft outline early on in the process so that the contractor does not go off in a direction without feedback. This would be similar to an interim report or interim deliverable that actually allows staff to look at the outline to ensure that the direction that the contractor is headed is to get staff the recommendations that will meet the goals of the study. Chairman Allenby acknowledged this is a good point. Chairman Allenby asked if there were any questions or comments.

Ms. Cummings stated that the Chair had overlooked Agenda Item 4d, a report on Proposition 86. This was on the agenda in the event that the initiative passed so that staff could discuss with the Board the impact on MRMIB programs and workload. The failure of the initiative means that in the immediate future, MRMIB must reinvigorate efforts to create an HFP buy-in for counties. Chairman Allenby asked if there were any further questions or comments. There were none.

Traditional and Safety Net List for 2007-08 Community Provider Plan Designation Process

Carolyn Tagupa informed the Board that the preliminary T&SN list was placed on the MRMIB website just before November 1st. Stakeholders have a 30-day appeal period to dispute these listings. The process will close on December 1st. Also included on the website are the CPP timeline and the letter of instruction. All of this information has been mailed to HFP participating plans. A hardcopy of the list also is available on the table outside the door. To date there has been just one appeal. Chairman Allenby asked if there were any questions or comments. There were none.

CHILDREN'S HEALTH INITIATIVE MATCHING FUND (CHIM) UPDATE

Buy-In

Sarah Swaney updated the Board on the status of the Buy-In project. MRMIB was authorized in 2005 to assess the feasibility of and to establish a county buy-in program to assist in the development of local children's health initiatives, also known as Healthy Kids Programs.

A major stumbling block for implementation has been fiscal liability for CCS services provided to children who are not financially eligible for CCS. This is not an issue in HFP where children are deemed eligible for CCS regardless of CCS financial eligibility criteria. Two plans currently in the Healthy Families Program plans—essential to provision of coverage in rural areas – have indicated that they are not willing to assume this financial liability. Counties are also unwilling and uninterested in participating if the risk is not mitigated. Staff has worked with PricewaterhouseCoopers in an effort to assess the risk but data problems have thwarted this effort. Staff then began assessing the possibility that reinsurance might address the problem. Ms. Swaney then introduced Mr. Dan Cavanaugh, of Brown and Brown, with whom staff has worked on obtaining reinsurance quotes.

Mr. Cavanaugh reviewed with the Board which companies had been solicited for quotes and the quote provided by the one company that has responded so far (from Ace American). There are five additional insurance carriers from whom quotes have been requested. The one quote received—and Mr. Cavanaugh expects this will be similar for any other quotes received, requires a specific deductible after which the reinsurer would pay 90% of costs.

Ms. Swaney pointed out that in reviewing the Healthy Families Program CCS data, staff found the highest paid claim in calendar year of 2004 to be $482,000, 38 percent of the amount actually billed. In year 2005, the

highest paid claim was $1.5 million - 69 percent of the amount billed. And in the current year, 2006, the highest paid claim to date is $700,000, 68 percent of the amount billed. In addition, staff noticed the ratio of inpatient or hospital claims to medical physician claims is approximately two to one. In fiscal year 2000/2001 that ratio was three to one. Hospital claims are three times as much as physician claims.

Ms. Swaney noted that the quote had premium costs per member per month ranging from $1.19 to $6.24, depending on the level of deductible. This cost would be built into the participating counties buy-in program cost. It would not be billed to the subscribers.

Next steps will be to obtain the one remaining quote and discuss with Healthy Families Program plans whether the reinsurance would mitigate their CCS risk concerns. Staff will survey the counties that have previously expressed interest in the Buy-In to determine their continued level of interest, and to assess whether they feel that the reinsurance option addresses their CCS risk concerns. Staff will also survey other counties to determine if there is additional buy-in program interest.

Chairman Allenby asked whether each county would be responsible for reinsurance or whether reinsurance would apply to all counties choosing to do the buy-in. Ms. Cummings replied that it would have to be the later. Chairman Allenby commented that it had to be that way given the small number of children that would be involved in a Buy-In.

Mr. Figueroa asked if the reinsurance costs were a surprise to staff, expressing the view that it would have required a lot of explanation to potential bidders. Mr. Cavanaugh noted that most carriers had declined to bid but that the one carrier that did bid is very familiar with the risk of the Healthy Families program.

Chairman Allenby asked if there were any other questions or comments.

Mr. Tim Shannon with Children's Specialty Care Coalition (CSCC) noted that he commented at the meeting September 20, 2006 and that CSCC had written a letter to MRMIB wherein his organization raised some policy questions. CSCC would like to discuss whether reinsurance is the right way to go.

He commented that the number of children not financially eligible for CCS would be small. It might be more appropriate to pursue legislation deeming this small number of children income eligible for CCS. CSCC is concerned that children who are not financially eligible would not have access to the specialty care for which CCS is known. Ms. Cummings replied that it is a policy issue, and one that MRMIB will delve into. But,

the first concern is trying to address what is stopping MRMIB from proceeding with implementing the Buy-In.

Ms. Cummings stated that legislation deeming children in Healthy Kids programs income eligible for CCS would be the simplest resolution to the problem, but waiting for legislation would also delay implementation. She thought that the larger counties with Healthy Kids programs would also want children in their programs to be included in any statutory deeming arrangement. She noted that income eligibility for CCS had not changed in over 20 years. Chairman Allenby commented that Ms. Cummings had recommended the present low level of eligibility when she was at the Legislative Analyst's Office many years ago. Chairman Allenby stated this is something MRMIB should take a look at.

Ms. Cummings said MRMIB staff would be happy to sit down and talk with Mr. Shannon further, but if MRMIB has intentions of bringing up the buy-in this year, it cannot wait for legislation.

Mr. Shannon acknowledged that this might be true but asked for a meeting with MRMIB staff to discuss the issue further. He thinks there might be a way to bring CCS in to the solution.

Chairman Allenby stated the Board is open to hear suggestions because MRMIB clearly does not have the answer. Mr. Figueroa asked if Mr. Shannon has discussed the possibility of legislation with the HFP plans with concerns about potential risk. Mr. Shannon indicated that he had not done so recently. Mr. Shannon opined that the plans might very well support legislation deeming children to be eligible for CCS, as it would clearly take care of the problem. Chairman Allenby thanked Mr. Shannon for his comments.

Mr. Figueroa commented that there have been a number of (failed) efforts in the past to increase the financial eligibility threshold for CCS.

Brenda Kaplan of Blue Shield had two questions: One, in the quote for reinsurance she saw coverage for hospitals and providers, but nothing for pharmaceutical. This struck her as a major omission given the potential costs in that area. Secondly, she wanted to know whether the costs of $482,000 cited by Ms. Swaney were based on what CCS pays or what a health plan would pay. Chairman Allenby stated he thinks it is CCS and it is considerably lower than what a plan might be paying.

Mr. Cavanaugh (of Brown and Brown) pointed out that pharmaceutical coverage is included under the physician coverage on this policy. It's not detailed in the exhibit that has been distributed. Brown and Brown have a very detailed quote that details coverage for various services.

Cherie Fields with Blue Cross stated Blue Cross would like to see the idea of reinsurance for the County Buy-In further explored. She noted that Blue Cross had recently experienced a case in which an HFP child who was moved out of the county left Blue Cross with significant financial liability for the child. Chairman Allenby thanked Ms. Fields for her comments.

Leah Morris with Health Net commented that Health Net is involved in Healthy Kids products in several counties, as well as Healthy Families. Health Net has been looking into reinsurance and would be happy to share what it has learned with MRMIB staff. Chairman Allenby thanked Ms. Morris.

Chairman Allenby commented that implementing the Buy-in was not easy but MRMIB would get there.

County Children's Health Insurance Program

Kathi Dobrinen updated the Board on the draw-downs of FFP for counties in the C-CHIP program. The total of federal matching funds for both quarters (third and fourth federal quarter for 2004) is just under a half-a-million dollars. Total county dollars thus far is slightly over $269,000 for both quarters. Matters of note: Tulare County has withdrawn its proposal to participate. Tulare County withdrew because the number of potential SCHIP eligible children enrolled in their program is lower than what they first thought it would be. The situation is not financially feasible for them to participate in CCHIP. Santa Cruz County's proposal has been reviewed and approved. MRMIB anticipates filing the SPA to include Santa Cruz in early 2007. There are a total of 22 counties that currently have Healthy Kids program implemented. MRMIB will be soliciting the other 16 counties to see if the counties are interested in participating in CCHIP. Chairman Allenby asked if there were any questions or comments. There were none.

ACCESS FOR INFANTS AND MOTHERS (AIM) UPDATE

Enrollment Report

Mr. Sanchez provided the Board with an update on the aforementioned report. He discussed in the month of October staff enrolled 939 mothers, bringing the fiscal year total to just less than 3,900. Currently there are 7,300 women enrolled in the program. The ethnicity breakdown has not

changed significantly. Latinos make up the largest percentage of the program. The top 18 counties account for 85.4 percent of the enrollment in the program.

Chairman Allenby asked if there were any questions or comments. There were none.

Administrative Vendor Performance Report

Mr. Sanchez provided the Board with an update on the foregoing report. All standards were met.

Financial Report

Glenn Hair reviewed the quarterly financial report.

Chairman Allenby asked if there were any questions or comments. There were none.

MAJOR RISK MEDICAL INSURANCE PROGRAM (MRMIP)

Enrollment Report

Mr. Sanchez reviewed the enrollment report. In the month of November, 860 new subscribers enrolled, bringing the current total to slightly under 7,900 subscribers. The current enrollment cap for MRMIP is 8,166. Ninety-one individuals currently are on the waiting list. These individuals will be offered slots for December 1st based on the information that will be presented later in the PricewaterhouseCoopers estimate.

Chairman Allenby asked if there were any questions or comments. There were none.

Administrative Vendor Performance Report

Mr. Sanchez presented the performance report. The administrative vendor for the MRMIP program, Blue Cross of California, has met its standards and has been consistently meeting its standards for a number of years.

Chairman Allenby asked if there were any questions or comments from the Board or the public. There were no questions.

Semi-annual Enrollment Estimate

Ms. Cummings introduced Sandi Hunt with PricewaterhouseCoopers (PwC) to present the semi-annual enrollment estimate. She indicated that Ms. Hunt would also comment on how much money it would take to fund the program if it were uncapped.

Ms. Hunt stated an enrollment estimate was prepared based on the claims experience of the MRMIP program and the Guaranteed Issue Pilot program. Projecting costs associated with the Guaranteed Issue Pilot continues to be difficult and the estimates are fairly volatile. In its estimate PWC has taken into consideration the additional $4 million the Legislature provided on a one-time basis for this year. Consistent with the Board's direction, PWC assumed that those funds would be expended in the one-year time period. On average, PWC finds that MRMIP enrollees remain enrolled for about 30 months.

With all of the information available and the additional $4 million in funding, PWC calculates a new enrollment cap of 9,182 people, about a 2 percent increase over current levels.

PWC was also asked to calculate the ongoing costs for the individuals who would be enrolled as a consequence of the additional $4 million. The first enrollment started for those individuals in October of this year. That means that in September the $4 million would be fully expended. For the remainder of the calendar year, PWC calculates that MRMIB will need an additional $1.2 million, and for each six-month period after that, approximately $2 million until those individuals disenroll from the program.

Dr. Crowell stated that it is important for the public to clearly understand what impact the one-time appropriation of $4 million had on MRMIP enrollment. Ms. Hunt replied that had the additional $4 million in funding not been provided there would have been a 2 percent drop in eligible enrollment. Health care trends for this population are running in the 12 to 14 percent range. For this year, the actual average premium increase was 2.7 percent. It is difficult to make a direct correlation between the additional funding and the numbers of people who can be enrolled. This is because health care costs are growing much faster than the amount that the enrollees are contributing towards their cost –something that happens on a cyclical basis. Last year it was the opposite.

Projection of MRMIP Costs

Ms. Hunt went on to discuss the amount of funding that would be required for calendar year 2007 and 2008 if MRMIP operated with no cap on enrollment determining this requires making a number of assumptions,

for example, the number of applications that would be received. Because MRMIP has operated without a cap only one time, PWC does not really know how many people would ask for coverage. Currently MRMIP receives about 500 applications a month on average and enrolls about 400 of those individuals. About 3 percent of the MRMIP enrollment leaves the program every month, not taking into consideration the individuals who leave because of the 36-month enrollment limit associated with GIP. GIP would continue to require about $15 million a year in subsidy funds until that program naturally exhausts itself. Subsidy costs would increase on a monthly basis according to health care trends. With these assumptions PWC calculated that for calendar year 2007 there would be a requirement for $48.5 million in funding. And for 2008, MRMIB would need $61.5 million in funding.

Ms. Cummings asked if this includes the $40 million or the $44 million. Ms. Hunt replied it did. Therefore additional funding needs would be $4.5 million in calendar year 2007 and $21.5 million in calendar year 2008.

Chairman Allenby asked if there were any questions or comments. There were no questions or comments from the Board or the public.

Federal Seed Grant Implementation Update

Ms. Cummings reminded the Board that MRMIB had received $150,000 under a federal seed grant to do work that would ultimately allow MRMIP to qualify for federal funds. There has been no funding provided for high risk pools for the next federal fiscal year, but efforts will continue to get those funds.

MRMIB has not done a review of its benefit plan design in a number of years. Statute actually precludes making any changes during the period of time in which the Guaranteed Issue Pilot is in effect. In the conversations and negotiations that occurred last year during debate on AB 1971, a number of issues were raised about the MRMIP benefit design. The bulk of these are actually issues that are within the Board's administrative authority to address if the board so chooses.

These issues will likely be revisited in any legislation introduced this year. Staff is recommending to the Board to spend some of the federal seed grant money to commission issue papers on topics that will be helpful to the Board in deciding whether or not it wants to change particular benefit features. Staff’s goal is to do the work in a timeframe that would allow the Board to make any changes in time for the next benefit year (2008). That would have been the effective date for any changes enacted by AB 1971. This information is being presented to the Board in draft format today. It will then be circulated to stakeholders involved in the AB 1971 process for

comment. Staff will bring this back to the Board at the December meeting advising the Board of those comments and any appropriate revisions.

For changes to be in effect at our next benefit year there are some timeframes that must be considered. Regulations would have to be adopted by the Board at the April 2007 meeting to be ready in January 2008. Materials included in open enrollment packets must be finalized by September 30, 2007. Plan contract changes must be in effect by May 16, 2007.

Ms. Cummings reviewed the topics staff is recommending for the commissioned papers. She noted that MRMIB's ability to make changes could be constrained by the fact that this is not a population that plans are eager to serve. Plans do not make a lot of money. The plans that do participate are basically doing it as good citizens. MRMIB does not expect plans to lose money, but the plans do not make much of a profit. It is difficult to get plans to participate in MRMIP. Therefore, this has been one of the reasons that the Board has not been prescriptive about a lot of the circumstances of the program.

Ms. Cummings began reviewing the issues. Regarding disease management, MRMIB presently relies on plans to provide it to MRMIP subscribers as they would their regular book of business. One of the first orders of business is finding out what the plans are doing vis-à-vis disease management.

Regarding case management: The difference between disease management and case management is disease management is over one particular disease, whereas case management recognizes that a person with one disease may have multiple diseases, co-morbidities. A case manager works to deal with the person as a whole. Staff believes the Board needs to be informed on what the state of the research is about and the efficacy of disease and case management and the document poses a number of questions aimed at discerning this. Staff will need to do an analysis of co-morbidities in the program as part of an assessment of the value of case management. The fact book provides information on the specific diseases reported by claims have been paid, as well as diseases reported by our subscribers. Currently, there is no information on co-morbidities.

Regarding benefits management: A question to ask is how do plans manage utilization and costs of MRMIP benefits now? And are there any additional steps that may be consistent with their business practices that would improve care or decrease costs? Prescription drugs are one example. There is variation in the prescription drug benefit by plan. There are incentives for use of generic drugs, but it isn't clear whether they are

set at the right level. It is important to look at how the prescription drug benefit is working now, and the extent to which MRMIB can improve it and make it more cost effective.

Regarding deductibles: A number of pools in the country provide a wide array of deductible options and some of them are exceedingly high. Blue Cross, in discussions on AB 1971, was opposed to having deductibles, arguing that overall it would increase the costs to the program, not decrease cost. Other carriers advocated for MRMIP to have an array of deductibles, arguing that MRMIP's coverage should be like that available in the individual market.

The first question is whether it is a good idea to provide multiple products with varying deductibles. What are the risk consequences of doing so? What is the implication for program costs overall?

Secondly, looking at just the issue of high deductible coverage and its applicability to a pool, there are a number of questions addressed at discerning whether high deductible coverage is being purchased by low-income people who do not get the health care they need due to their high deductible? Or is it being purchased by lower risk people, in which case there is segmentation of risk in the pool. And is there value in so doing? When somebody doesn't pay a deductible, what's the impact of that on uncompensated care? How would the MRMIP population distribute if they all purchased in this way. What are the overall implications for the cost of the pool?

According to Ms. Cummings these latter topics about deductibles will require a statutory change if the Board decides to do a deductible over $500. Therefore, in order for this to be in effect at the beginning of the benefit year, any legislation will have to be passed no later than July 2007.

Chairman Allenby asked for any questions or comments from the Board. He stated that the Board would hear comments from the public at the next meeting to save any comments from the floor for next month.

Financial Report

Mr. Hair reviewed the quarterly financial report. Chairman Allenby asked if there were any questions or comments. There were none.

At 12:35 p.m., the board meeting was duly adjourned.